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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF1 Belgium**  **June 2019** |
| Job role | Psychologist |
| Organisation | Hospital |
| Public/Private/Both | Public |
| Interviewer initials | TG |
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| **Interview summary** | Works at a large center in Belgium that collaborates with other centers in the country.  In this center they do not recruit the donors directly or use broker or agencies. This doctors states they try to stay away from commercial donor eggs because they fear the way those donors are treated.  The donor eggs retrieved in this center are only being used to treat their own patients. They don’t sell of exchange eggs to or with other centers.  The donors in this center are screened thoroughly in different areas, including medical, personal, genetic and psychological anamnesis and tests. After the donation they are asked back to check if their body and specifically their ovaries are fully recovered from the treatment.  In this center, they only use fresh donor eggs. They used to have an egg bank, but they stopped using frozen donor eggs because they are convinced fresh cycles give better results.  In this center the whole donation team (doctors, midwives, psychologists,…) are responsible for the wellbeing of the donor. The midwives tend to be the first person the donor contacts if there are problems. But if needed the donor can always ask for a (second) consultation with the psychologist even if the donation itself was years ago.  In her day to day practice she likes to use non-directive counseling.  They would like to see that the amount of compensation is determined by law. This way the compensation would be the same in every center in Belgium. This would avoid possible competition between centers not that there is much competition according to this doctor.  Concerned about the shortage of egg donors. Believes that if the anonymity would be lifted there would still be egg donors because they often have a certain need to help other women/couples and want to share certain information with the acceptors/donor children because they themselves are already a mother. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF2 Belgium**  **June 2019** |
| Job role | Midwife |
| Organisation | Hospital |
| Public/Private/Both | Public |
| Interviewer initials | TG |
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| **Interview summary** | Works 100% with egg donors. Estimates that there are around 50 anonymous and 50 known egg donation cycles in a year.  They are not allowed to recruit the egg donors directly. The donors in this center applied all on their own initiative and the eggs retrieved from them are kept in the center itself. So they use the donor eggs to treat their own patients. In this center they don’t use brokers or agencies. They also don’t buy or trade eggs with other centers.  Donors have to undergo screening tests. All the screenings test above are discussed during a staff meeting where they decide whether to accept or refuse the applicant.  The donor know beforehand what the screening procedure is during the intake through the telephone and also get to know the result afterwards at the consultation with the doctor.  In this center the donation of the eggs is always a fresh donation. this means there are no eggs being frozen and donated after they are frozen and thawed.  For every donor they match one or two acceptors. When the pick-up takes place they either use all the eggs for one acceptor. If there are enough eggs they divide them between the two acceptors  In this center they match on certain external characteristics. The matching is done by the midwifes that are responsible for the egg donors at the center. The midwife describes their approach as very patient-oriented. She explains that they often have a lot of acceptors waiting for a donor. They already know these acceptors and know what they look like which makes the selection in some way easier.  Thinks that the compensation should be the same nationwide - there are a lot of different rates of compensation across the centers in Belgium. The compensation used to be 500 euros and since they changed it to 1000 euros they have noticed a rise in applications. They also notice that there are more donors that donate more than once.  The professional is convinced that their donors are being pampered. The donors are frequently contacted during the stimulation to check up on them. After the donation they are contacted every day after the pick-up until the midwives feel that the donors are alright. They are also invited back to get checked by the doctor. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF3 Belgium**  **July 2019** |
| Job role | IVF-Consultant |
| Organisation | Hospital |
| Public/Private/Both | Public |
| Interviewer initials | TG |
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| **Interview summary** | Suggested that there have been many more donors in the past 4 years because the hospital has actively advertised in the local newspaper and on the local television channel.  The centre does not allow donors with only financial motivations. They have refused people in the past who wanted to donate for the extra financial income. She believes that these individuals are not able to estimate the risks of donation.  When asking about donor support and donor well-being, suggests that donors have the possibility to contact the centre when they have problems or questions. She thinks that donors are well informed in the centre.  They base matching on phenotypes such as eye and hair colour. Blood group and body type if an option for recipients. If possible, the shape of the face is also taken into account.  She described some risks of egg donation including cancer (although notes there is no scientific evidence for this), bleeding, OHSS, expanded ovaries. She states that donors are not often concerned about the risks and have high pain thresholds. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF4 Belgium**  **July 2019** |
| Job role | Clinician |
| Organisation | Fertility clinic |
| Public/Private/Both | Private |
| Interviewer initials | CH |
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| **Interview summary** | Is in contact with egg donors and recipients and manages the procedures. Noticed only a slight increase in demands over the past years.  Recipients are reimbursed for the tests and IVFs (if in the age criteria) but not for the egg donation itself. The recipient will pay part of the donor’s medical consultations and expenses, so the donor doesn’t need to pay the medical consultation. However, the tests taken by the donors (eg screening) will be reimbursed by her own health insurance as it is considered to be information which can be useful for her. The clinic try to help the donor where they can.  Purchase of eggs from Spain – they try to do group orders so costs are divided between recipients. She notes this can be expensive but at least recipients don’t have to go to Spain and parts of their medical expenses in Belgium are covered by the national health insurance. The clinic does not make any money out of it.  Initially she always encourages recipients to find a donor themselves but now that patients know that the possibility to get eggs from Spain exists, more are asking for it, even if it is more expensive: at least 70% patients now prefer to go for eggs bought in Spain. Thus, less patients are travelling abroad to get egg donation.  Very rare to have donors who present themselves spontaneously. Those who want to volunteer go to a center where it is better compensated. Frustrated by the lack of standardised compensation in Belgium.  They use both fresh and frozen eggs but increasingly more frozen ones, as it makes things easier. When it is a cross donation, they try to do a first fresh cycle but not always possible. Always use fresh eggs for direct donation.  At present they tell the donors that they are doing genetic tests beforehand and if they find out any problems, they inform them. It is very rare that they refuse people for medical reasons. Usually more for relational issues e.g. they realise the donor is under pressure.  She always offers to meet with the donors one month after the donation to check that everything is ok. No proper psychological consultation but they are asked how they are doing. 95% donors attend this follow up meeting. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF5 Belgium**  **July 2019** |
| Job role | Clinician |
| Organisation | Fertility clinic |
| Public/Private/Both | Public |
| Interviewer initials | CH |
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| **Interview summary** | Works at a large size university clinic. The number of donation cycles has slightly decreased recently because they currently have problems in recruiting staff but should be resolved soon. However, increase in known/direct donation from French patients from 2000’s as this is not authorized in France, and increase in demand from older women.  Recruitment of donors is only via recipients (‘relational donors’ e.g. relatives or friends, though some recipients sometimes recruit via internet). In over 20 years, there has only been about 10 ‘spontaneous’ donors.  Currently the clinic sees ~30-40% direct donation and 60-70% cross (anonymous) donation, while it used to be rather 90% cross donation in the a couple of decades ago. They have been encouraging direct donation in her clinic.  They refuse at least 25% of potential donors due to genetic or health reasons, family history of illness, low ovarian reserve, psychological reasons.  The same number of donated egg are used for each recipient, whatever the number of eggs their relational donor has produced. Need to be fair to each recipient.  She doesn’t think egg donors’ profile has changed over the years: still donate for altruistic reasons and most of them don’t even know that they will be compensated 500EUR. She thinks that 1000EUR would be more appropriate and that all the clinics should pay the same amount to avoid any kind of competitions and donors going where it is better compensated.  They are looking into buying/importing eggs soon which will mean that patients will not have to go to Spain.  They are getting increasing demands from families where young girls have cancer and their mums/aunts want to donate and freeze their eggs for future uses. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF6 Belgium**  **July 2019** |
| Job role | Nurse |
| Organisation | Fertility clinic |
| Public/Private/Both | Public |
| Interviewer initials | CW |
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| **Interview summary** | Works at a university clinic. Egg donation is only a small part of the services provided by the clinic, but an important part.  There has previously been a waiting list for egg donation meaning that recipients had to wait 2-9 months, but this has improved over time. The duration of waiting depends on the required phenotype (blood, skin colour, hair colour, eye colour); Belgian/European recipients wait the shortest time, whereas African and Asian recipients wait longest;  The clinic neither imports or exports eggs; all eggs that are in the egg bank are from cycles conducted in the clinic, following their selection and screening criteria  Donors come forward to her clinic because they are aware of the need for donors and the opportunity for donation through media and social media; but often they heard about it also through friends and colleagues.  By far the largest group are anonymous donors (90%), and occasionally they have known donors and cross-over donation. In anonymous donation, all cycles are frozen cycles - in fresh cycles you may run the risk that the donor doesn’t produce enough good quality eggs.  Recipients receive 8 eggs as a standard and are informed ahead that not all 8 eggs may thaw well, and that they will work on an average of 4-5 good quality eggs to have 2-3 good quality embryos. If there are no more eggs of that donor available, she will thaw eggs of another donor who matches by hair and eye colour and blood type.  The nurse is responsible for the matching, and also for the immediate matching if a lower number of eggs thaw well and they need to thaw more, or from another donor.  In her clinic, she does all the counselling. Her original training is that of a midwife and nurse, and 10 years ago she became involved in IVF, and in the past months only in egg donation.  When possible, she personally visits donors after they wake up to check on them; all donors can call back or email any time after a treatment, but a follow-up in person appointment is not required. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF7 Belgium**  **2019** |
| Job role | Gynecologist |
| Organisation | Fertility clinic |
| Public/Private/Both | Both |
| Interviewer initials | LP |
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| **Interview summary** | Egg donation takes up 50% of his work activities. He works with two different fertility centers (located in different hospitals).  Noticed a rise in demand of egg donors and states that they see more egg donors than recipients.  In both fertility centers all of the donors apply voluntarily and on their own initiative. He does not recruit the donors on his own or uses brokers or agencies and is also opposed to working with those kind of organization.  They do not search for a specific type of egg donor however they do have some criteria that the applicant must meet before she is accepted as donor. For Caucasian donors they set the age limit between 18 and 30. For African and Asian donors they allow donors between 18 and 35. The reason for the difference in age limit is because they do not have a lot of African and Asian applicants which keeps them from being as strict.  Describes the screening as very strict. States around 40% of the applicants are turned down because of a reason that came to light due to the screening tests, for example genetic of infectious anomaly. However the most common reason for refusal is a low level of anti-Mullerian hormone (AMH).  They do have an egg bank where they keep frozen eggs. They use this in case an donor does not want to go through with the donation but the acceptor has already started or when the donor does not have any eggs after pick-up.  The recipient receives all the eggs that were able to be retrieved from the donor. It does not matter how many or how little eggs were retrieved. The only exception to this could be when they have an Asian donor with a lot of eggs because of the fact that Asian donors seem to be rare.  He prefers the fresh cycles because they tend to give better results. The disadvantage of this way of working is that they have to synchronize the cycle of the donor and the acceptor.  The donors are informed that they match donor and acceptor based on the phenotype of the future mother. The most important thing is that the future child can recognize him-/herself in their birthmother. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF8 Belgium**  **2019** |
| Job role | Gynecologist |
| Organisation | Hospital |
| Public/Private/Both | Public |
| Interviewer initials | LP |
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| **Interview summary** | This professional is a gynecologist in a hospital. He sees many patients including recipients as well as potential donors.  The gynecologist describes the egg donation process/program as labor intensive because of the required screening process etc in comparison to ‘normal’ IVF-patients for example. According to him it is way easier for a center/professional to just refer patients who need donor eggs to another center (eg. Spain) instead of recruiting egg donors themselves. Because of this he says the incentive to recruit egg donors is not that high.  Pending law change concerning the anonymity - according to him this already influences the choice of potential egg donors to donate or not in a negative way  Because of the shortage in egg donors this center has to work with a waiting list for anonymous donor eggs. The waiting period contains 6 months or longer.  Potential donors are selected based on their anti-mullerian hormone levels and age. These two together give a good indication of the oocyte reserve.  The donors are also informed about the results from the screening tests.   The donors do not have to have children of their own (in context of proven fertility). According to this professional there is no reason why this should be a demand/criteria.  In this center they use fresh as well as frozen egg donation cycles, depending on the situation. He himself does not really have a preference. The two types of cycles have their own advantages and disadvantages.  In order to guard and respect the wellbeing of the donor, they follow the donors quite closely and the guidance is very personal. They set up a special donation team consisting out of two midwives that closely follow up on the donors. |

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| **Interview ID Code**  **(Interview number; country) and date of interview** | **PROF9 Belgium**  **2019** |
| Job role | Gynecologist |
| Organisation | Hospital |
| Public/Private/Both |  |
| Interviewer initials | LP |
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| **Interview summary** | This professional is part of the donation team and is responsible for the more medical (gynecological) side of the donation.  The center where this gynecologist works is a tertiary center. Meaning that patients who apply here already have come a long way when it comes to their fertility treatment. These patients/women often have had a lot of (failed) IVF-cycles before applying which means that a big percentage of the patients who apply in this center are already candidates for egg donation.  The gynecologist has noticed that in recent years the demand for egg donors has increased yet again and they have a waiting list for anonymous donor eggs.  In regards to egg donor recruitment, they guide and advise egg acceptors to try and search for a possible egg donor in their own environment. Most of the time these donors and acceptors opt for cross donation.  Aside from more medical type of screening the donor also have to see a psychologist at least once before being allowed to donate.  They try to match donor and acceptor based on their fenotypes – she describes a few cases where the acceptors come to show their child and the donation team is just astonished by the resemblance to the birthmother. She does however admit that this kind of matching is only possible when you have a donor bank with several types of fenotype.  All donors receive the same amount of compensation even when they have little or no eggs after pick-up.  Explains there are two main points when it comes to donors well being: The donor’s health must not be harmed and they must be able to guarantee as much as possible that the donor eggs will lead to a healthy child.  She finds it very important that the donors are thoroughly counseled about the risks, the consequences as well as the way they will deal with certain situations (in the future). This professional also wants to prepare the donor for possible failure of the anonymity because of the ‘donation detectives’ and other current initiatives like 23andme. |